U.S. Department of Labor

Office of Administrative Law Judges
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Date Issued: January 30, 2001

Case Nos.: 2000-LHC-363/2000-LHC-1430

OWCP Nos.: 07-118688/07-120669

In the Matter of:

CLYDE STRAHAN,
Claimant

against

AVONDALE INDUSTRIES, INC.,
Employer

APPEARANCES:

ARTHUR J. BREWSTER, ESQ.,
On behalf of the Claimant

RICHARD S. VALE, ESQ.,
On behalf of Employer

BEFORE: RICHARD D. MILLS
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This is a claim for benefits under the Longshore and Harbor Worker's Compensation Act (hereinafter "the Act"), 33 U.S.C. § 901, et seq., brought by CLYDE STRAHAN ("Claimant") against AVONDALE INDUSTRIES, INC. ("Employer") for injuries allegedly sustained during the construction

of a vessel.

The issues raised here could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. A formal hearing was held May 10, 2000 in Metairie, Louisiana.

STIPULATIONS

Prior to the hearing, the parties agreed to a joint stipulation (JX-1):[1]

> 1. The Claimant was injured on two separate occasions on May 22, 1990 and September 25, 1990;
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> 2. At the time of the Claimant's injuries an Employer/Employee relationship existed between the Claimant and Respondent;
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> 3. Claimant timely filed notice of his injuries on May 22, 1990 and October 25, 1990 and Employer filed timely notices of controversion on November 20, 1990 and February 1, 1991 respectively;
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> 4. Claimant was paid temporary total disability from June 9, 1990 until June 13, 1990 and from October 1, 1992 until September 29, 1999 at $192.69 per week. Claimant was also paid temporary total disability from November 5, 1990 until July 28, 1991 and from June 5, 1992 until June 22, 1992 at a rate of $206.72 per week;
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> 5. Medical benefits have been paid to the Claimant in the amount of $123,807.90 and continue to be paid by the Employer;
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> 6. The Claimant reached maximum medical improvement with respect to his leg on July 19, 1991.

ISSUES

The parties also listed the following specific issues as unresolved:

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[1] The following references will be used: TX for the official hearing transcript; JX-__ for Joint exhibits; CX-__ for the Claimant's exhibits; and RX-__ for Employer's exhibits.

1. The causation of Claimant's continuing problems by his accidents on May 22, 1990 and September 25, 1990;

2. The nature and extent if any of Claimant's psychological disability;

3. Average Weekly Wage;

4. Respondent Employer's liability for payment of future reasonable and necessary medical expenses;

5. The nature and extent of Claimant's physical disability;

6. The period for which Claimant is entitled to compensation benefits.

SUMMARY OF FACTS

I. Claimant's Employment

Clyde Strahan, the Claimant, is a 52 year old divorced resident of New Orleans, Louisiana. He has lived in New Orleans all his life and attended school in that city. (TX, p. 25). His education is complete through the ninth grade. In addition, he completed a federal job training program in New Orleans where he attained various construction related skills. (TX, p. 26). He also attended the welding and plumbing school offered by Avondale Shipyards, his employer. He became a certified welder in the 1960s (TX, p. 27).

Subsequent to his certification as a welder, the Claimant was a welder at American Marine, Quarterly Equipment, Miko, and Todd Shipyard's California location. He also worked for a yard in Chester, Pennsylvania. (TX, p. 27). In addition to these experiences, Claimant also worked as a carpenter in California. (TX, p. 28). He also worked as a longshoreman for 5 years with the local longshoremen's union in New Orleans. (TX, p. 28).

Claimant testified that he worked for Avondale Shipyards (hereafter Employer) on several different occasions. His most recent employment with Avondale began in 1989. (TX, p. 29). The Claimant testified at trial that he took a pre-employment physical and was hired at Avondale as a first-class shipfitter. (TX, p. 30). His duties in this position included welding bulkheads, stairs, doors, and other parts of ships in the yard. (TX, p. 30).

II. Claimant's Injuries

Prior to his employment with Avondale, Claimant testified that he had suffered only one prior injury for which he lost any time. (TX, p. 29). During his tenure with Avondale, however, he suffered two different injuries that caused him to miss time from work. His first injury occurred when he tried to prevent

a steel beam from falling on another worker. As the crane lowered the beam into the ship and Claimant's team of shipfitters were bracing it into position, another worker accidentally cut the top of the beam, causing it to fall. (TX, p. 31). Claimant got between the beam and another worker to prevent it from crushing the other person. (TX, p. 32). When the other worker got out from under the beam, it shifted, injuring the Claimant. (TX, p. 32).

Claimant testified that after he was extricated from the beam, he went to the first aid clinic and saw the nurse and Dr. Mabey. (TX, p. 32). Claimant's initial complaint's were of back, neck, and knee pain. He believes that Dr. Mabey gave him some medication. He testified that Dr. Mabey put him off of work for several days after this accident. (TX, p. 32). He continued to see Dr. Mabey for a period after the accident. He was treated with hot packs and was ultimately released to work, first at light duty. (TX, p. 33). Claimant testified that with the assistance of therapy and pain pills from Dr. Mabey, he was able to continue to work at light duty.[2] (TX, p. 34).

Some time after he returned to work, Claimant suffered a second accident and injury. In this case, he was coming down a gangplank to go to the tool shed. As he returned to the ship up the gangplank he slipped, fell, and hit his knee. (TX, p. 34). Claimant testified that at the time of this accident he was still having problems with his back and neck from the previous accident. He had seen Dr. Mabey that day, and after he hurt his knee he went to see Dr. Mabey again.[3] (TX, p. 34). Doctor Mabey apparently treated the Claimant for this injury by having him sit in a whirlpool and giving him more pain medicine. (TX, p. 35). The Claimant tried to keep working after this accident, but was unable to. (TX, p. 35).

Claimant testified that following his second accident his leg was swelling and that his pain was not relieved by Dr. Mabey's treatment. Claimant went to see Dr. Farris, an Orthopedist, in Marrero, Louisiana. (TX, p. 35). Doctor Farris sent the Claimant to physical therapy and took X-rays of his knee. Farris concluded that the Claimant needed surgery on his knee. (TX, p. 36). Claimant was transferred to the care of Dr. Russo for this surgery because Dr. Farris was called to serve in the Gulf War. (TX, p. 36).

Claimant reports that he also told Dr. Farris and Dr. Russo about his problems with his neck and back, but that they did not offer treatment for those problems. After returning from the Gulf War, Dr. Farris resumed treatment of the Claimant and sent him to physical therapy at West Jefferson Hospital. Subsequently, Dr. Farris referred the Claimant to his partner, Dr. Klainer for treatment of his neck and back injuries. (TX, p. 39). Doctor Klainer apparently determined after examining the Claimant's back and neck that he had problems with several of his spinal discs which would require surgery. (TX, p. 40).

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[2]In contrast, Dr. Mabey testified that Claimant was released to work, at his request, with no restrictions. (CX-22, p. 8, 13).

[3]This is inconsistent with Dr. Mabey's records which show that the Claimant did not see him for this injury until October 16, 1990. (CX-22, p. 29).

III. Claimant's Medical Treatment

Claimant's medical treatment for both injuries suffered while at Avondale was performed by 5 physicians. Doctor Mabey provided initial care for the Claimant for both injuries. Doctors Farris and Russo provided care for the Claimant's knee problem when it became more serious. These physicians referred the Claimant to Dr. Klainer for treatment of his ongoing back and neck pain. When Dr. Klainer suffered from cancer, Dr. Fleming took over the Claimant's treatment on his behalf. In addition to these physicians, Claimant saw a number of doctors for independent medical evaluations and second opinions. He was also referred to four different psychiatrists or psychologists by Dr. Fleming and others for treatment related to his workplace injury.

Treatment for Claimant's First Injury

Claimant's initial injury occurred on or about May 22, 1990. (JX-1). He saw Dr. Mabey[4] at the shipyard hospital immediately after that injury. (CX-22, p. 6; TX, 32). Claimant presented to Dr. Mabey complaining of neck and back pain. (CX-22, p. 7). Doctor Mabey did a complete examination of the Claimant's neck, back, and dorsal back which was negative except for the reported soreness. (CX-22, p. 7). Based on his examination of the Claimant, Dr. Mabey diagnosed him with a strain of several muscle groups in his back. He treated the Claimant with non-steroidal anti-inflammatory medication (NSAIDs)[5] and muscle relaxants.[6] Doctor Mabey explained that the Claimant was to return to see him the following morning in case of any delayed complaints. The Claimant could not comply because of a previous appointment with another physician. (CX-22, p. 8). As of the date of the accident, the Claimant was released to return to work. No restrictions were placed on the Claimant at that time. (CX-22, p. 8).

Doctor Mabey explains that the Claimant's condition improved over the next several days. By the time Dr. Mabey saw him on May 29, 1990, Claimant indicated that his physical complaints were so much better that he only wanted to take the prescribed muscle relaxant and discontinue the physiotherapy that Dr. Mabey had recommended. (CX-22, p. 9-10). On June 1, 1990 Dr. Mabey was again visited by the Claimant. On this visit, the Claimant complained of episodic short muscle spasms of his dorsal back. (CX-22, p. 10). Doctor Mabey examined the Claimant that day and determined that his condition was "normal for his age group" with some minor discomfort of his lower back and his latissimus dorsi. (CX-22, p. 11). X-rays further revealed that the Claimant had suffered some slight degenerative changes of the lower

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[4]Dr. Joseph F. Mabey is a specialist in general surgery who graduated from Temple Medical School in 1943 and interned at Graduate Hospital at the University of Pennsylvania, served at United States Army hospitals through World War II, attended the Graduate School of the University of Pennsylvania in General Surgery. He is board certified in General Surgery and is a member of the College of Surgeons.

[5]Dr. Mabey specifically prescribed Naprosyn.

[6]Dr. Mabey specifically prescribed Parafon Forte.

cervical vertebrae and the lumbar back. Based on this examination, the Claimant was diagnosed with muscle strain. Dr. Mabey prescribed more NSADs, as well as Vicodin for the pain and continuing physiotherapy. Doctor Mabey released the

Claimant to work full duty on that date. The Claimant indicated that he was leaving early that day because he had other business to attend to, not because of his back. (CX-22, p. 12). No restrictions were placed on the Claimant's return to work as of June 1, 1990. (CX-22, p. 13).

Claimant returned to Dr. Mabey on June 5, 1990. That day his principle complaint was that his helper had been taken away from him in the yard. Doctor Mabey indicates that the Claimant was extremely agitated.[7] Doctor Mabey testified that the Claimant complained of muscle swelling because he did not have a helper in the yard. Mabey thought that the Claimant's job dissatisfaction was obvious and recommended that he be put on restricted work. (CX-22, p. 13). No restricted duty was available, and the Claimant was accordingly placed on lost time, meaning that he was sent home from work for a given period. (CX-22, p.14). This is in marked contrast to Claimant's testimony that he was released from work because of his back pain. (TX, 32).

Claimant also returned to Dr. Mabey on June 11, 1990 complaining of back pain secondary to mowing his lawn at home. (CX-22, p. 14). Claimant thought that his muscles were swollen, but Dr. Mabey testified that his examination of the Claimant was entirely negative except for the claim of slight soreness. (CX-22, p. 15). The Claimant was returned to work on June 14, 1990. (CX-22, p. 16). He also saw Dr. Mabey at the base hospital on June 15. At that time, he continued to complain about the work load and the pain that he was suffering in his neck and back despite the fact that Dr. Mabey indicated that the Claimant's physical examination was normal. (CX-22, p. 17). Claimant was returned to work on June 15, 1990 with restrictions to be careful. Mabey indicated that this was mostly due to his job dissatisfaction. (CX-22, p. 18). Indeed, when the Claimant returned to the clinic for another injury on June 20, 1990, he made no complaints of back or neck pain. (CX-22, p. 20).

Despite several intervening opportunities, Claimant did not register another complaint with Dr. Mabey about his back and neck until August 14, 1990. On that date he came to see Dr. Mabey after wrenching his back while pulling on a welding line. The doctor testified in his deposition that his examination of the Claimant was entirely negative. (CX-22, p. 23-4). Doctor Mabey again diagnosed the Claimant with a mild dorsal back sprain and returned him to work. (CX-22, p. 24-5). In Dr. Mabey's opinion, Claimant had reached maximum medical improvement for his neck, shoulders, spine and back by September 18, 1990. (CX-22, p. 27).

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[7]Dr. Mabey's testimony is that a patient has never screamed so loudly about having their helper removed before. (CX-22, p. 13-4).

There is no other record of treatment of the Claimant for his injury on May 22, 1990. Claimant also does not indicate in his testimony that he required further treatment or saw another physician besides Dr. Mabey for this injury. (TX).

Treatment for Claimant's Second Injury

Claimant reported to Dr. Mabey on October 16, 1990 for his second injury. That injury occurred on September 25, 1990. (CX-22, p. 29). He complained that he suffered an injury to his right knee while bringing a heavy piece of steel up the gangplank of a ship in the Avondale yard. (CX-22, p. 28). Claimant told Dr. Mabey that his knee was sore. X-rays showed no obvious acute change. Accordingly, Dr. Mabey felt that the Claimant needed to decrease the stressful use of his knee. He also prescribed a knee brace and daily whirlpool therapy and gave the Claimant an anti-inflammatory medication. (CX-22, p. 31). Doctor Mabey released the Claimant to return to work as of October 16, 1990.(CX-22, p. 31).

Following a continuing series of physiotherapy sessions, Dr. Mabey ordered the Claimant to undergo an MRI to look for additional changes to his knee. (CX-22, p. 33). The MRI results indicated that the Claimant's knee problems were mostly degenerative. Based on this study, Dr. Mabey diagnosed the Claimant with overuse syndrome affecting his right knee. In order to combat this problem, he suggested that the Claimant restrict the use of his right knee. He also recommended reclassifying the Claimant. (CX-22, p. 35).

Dr. Mabey referred the Claimant to the care of Dr. Farris in November of 1990 for treatment of the right knee. (CX-22, p. 35). Doctor Mabey testified that the Claimant did not complain of back or neck pain during this entire period of treatment for his knee injury. (CX-22, p. 36). When Claimant attempted to return to work after surgery in August of 1991, he complained of continuing back pain. Doctor Mabey testified that he thought this continuing back pain was the result of other factors, and not of his earlier workplace injury. (CX-22, p. 37).

Doctor Farris picked up the treatment of the Claimant in early November of 1990. He originally diagnosed the Claimant with meniscal pathology. (EX-9, p. 1). He sent the Claimant to physical therapy. (EX-9, p. 1). When the Claimant returned on November 29, 1990, he had not been to physical therapy and his knee was still tender in the medial compartment. (EX-9, p. 2). Doctor Farris called the physical therapist and made a new appointment for the Claimant and ordered him to return to the clinic on December 18, 1990. (EX-9, p. 2). When the Claimant returned on December 18, 1990 it was apparent that the Claimant's condition was continuing and that he needed a diagnostic arthroscopy of his right knee. (EX-9, p. 3).

At this point, Dr. Russo took over the treatment of the Claimant for Dr. Farris who had been called

to military service in the Persian Gulf. (EX-9, p. 3). Doctor Russo first saw the Claimant on December 28, 1990 and concurred with the recommendation of a diagnostic arthroscopy. (EX-9, p. 4). Subsequent to his arthroscopy in January of 1991, Claimant was listed by Dr. Russo as doing well. Russo sent the Claimant to physical therapy for range of motion and progressive resistive therapy exercises and prescribed Vicodin for his pain. (EX-9, p. 5).

In February of 1991, Claimant sustained a slight re-injury of his knee while working in his yard. Doctor Russo instructed the Claimant to continue using his crutches and gave him a neoprene knee brace to keep the swelling down. He continued the Claimant on his existing no work duty status. (EX-9, p. 7). From this point on, Dr. Russo instructed the Claimant to continue with physical therapy in order to strengthen his knee so that he could eventually return to work. (EX-9, p. 8).

Doctor Farris returned and resumed treating the Claimant on April 17, 1991. In his narrative from that date, he indicates a continuing need for physical therapy and that the Claimant is now complaining of back and neck problems. Farris had no record of prior back and neck complaints. He recommended the Claimant to physical therapy for strengthening of his quadriceps. (EX-9, p. 10). Similarly, Dr. Russo reported on May 6, 1991 that he had no record of the Claimant complaining of back or neck pain. Based on this absence of record, he opined that the Claimant's back had had time to recover from his injury in the early summer of 1990. (EX-9, p. 11).

By June of 1991, Dr. Farris felt that the Claimant had made a significant recovery from his knee injury and sent him to a physical therapy work hardening program. According to Farris' correspondence with Avondale, Claimant refused to participate fully in this final step of his therapy. (EX-9, p. 20). Doctor Farris also notes that he is at a loss to explain the Claimant's persistent complaints of neck and back pain as these were not originally part of his complaints. (EX-9, p. 19).

On July 19, 1991, Claimant saw Dr. Farris at the Westside Orthopedic clinic for follow-up treatment. (EX-9, p. 21). At that time, Dr. Farris felt that the Claimant had reached maximum medical improvement from his knee injury and resultant surgery. Doctor Farris opined in his letter after this visit that the Claimant could return to work and released him from further treatment. (EX-9, p. 21). Doctor Farris also explained that he could not offer any assistance with regard to the Claimant's back pain because the Claimant had never complained of this pain to Dr. Farris. (EX-9, p. 21).

Further Treatment

Claimant did not return to Dr. Farris' clinic until May 7, 1992. At this point, he returned complaining of pain in his cervical and lumbar spine. Upon examination Dr. Farris felt that the Claimant might have a slight soft tissue injury and therefore referred him to physical therapy. (EX-9, p. 22). Doctor Farris instructed the Claimant to attend a physical therapy work hardening program. When the Claimant

failed to participate and showed a lack of motivation, he was discharged from this program. He was also discharged from Dr. Farris' care as of July 1, 1992. At that time Dr. Farris opined that the Claimant was capable of returning to work. (EX-9, p. 24).

Claimant returned to see Dr. Farris on September 10, 1992, again complaining of neck and back pain. This time Dr. Farris recommended an MRI of the Claimant's back and neck for diagnostic purposes. (EX-9, p. 25). By this point the Claimant had not been employed for more than two years. (EX-9, p. 24). The results of the MRI showed that the Claimant indeed had some abnormalities at the L5-S1 level. (EX-9, p. 26).

As of October 13, 1992, Dr. Farris referred the Claimant to Dr. Naum Klainer of the West Side Orthopedic Clinic for his complaints of back and neck pain. (EX-9, p. 26). Dr. Klainer treated the Claimant for this injury, which he described as serious. He also opined that this was due to the original injury, the date of which he lists as May 12, 1989. (EX-9, p. 15-6). Obviously, this claim is incongruent with the Claimant's testimony that his back and neck injury related to a workplace accident on May 22, 1990, more than a year later.(JX-1; TX, p. 32). Regardless of the inconsistencies, Dr. Klainer referred the Claimant for surgery. (EX-9, p. 15). At Dr. Klainer's recommendation, Dr. Robert Fleming performed an anterior cervical fusion on the Claimant. (EX-9, p. 15).

Doctor Fleming performed surgery on the Claimant on May 19, 1993, nearly four years after his initial accident. (EX-9, p. 36). This surgery unquestionably improved the Claimant's neck condition. (EX-9, p. 41). It was not until four months later that the Claimant returned to see Dr. Klainer and complained that he was still having problems with his lower back. Dr. Klainer evaluated that claimant and determined that further studies were needed of the Claimant's L5-S1 spinal disk. (EX-9, p. 41-2). In November of 1993, the Claimant underwent further surgery, a lumbar laminectomy, to attempt to repair a herniated disc in his lower back. (EX-9, p. 45). Two weeks after this surgery Dr. Klainer felt that the Claimant was improving significantly despite continuing post surgical back pain. (EX-9, p. 45). Five weeks after surgery the Claimant was recovering well, but needed an additional medical device to assist with completion of the fusion. (EX-9, p. 46). After four months, it was clear that the second surgery was only partially successful. Dr. Fleming, however, believed that the Claimant was sufficiently healed to warrant only the continuing use of his brace. (EX-9, p. 51). At this time, Dr. Fleming also opined that the Claimant's cervical spinal injury had completely healed and that he could re-mobilize his neck. (EX-9, p. 51).

By October of 1994 it was clear that the lumbar fusion surgery had failed. The Claimant was scheduled for an additional surgery in November of 1994. (EX-9, p. 55). A difference of opinion between Dr. Fleming and an independent medical examiner, however, lead to the Claimant not having surgery. Dr. Fleming felt that mobilizing the Claimant's lumbar spine would determine whether or not the Claimant actually required further surgery. (EX-9, p. 58). When the Claimant's physical findings were unchanged, he was again scheduled for surgery. (EX-9, p. 59). Through surgery and additional physical therapy and bracing, the Claimant eventually recovered from his lower back condition. (EX-9, p. 60-65).

On February 3, 1997 Dr. Fleming recommended that the Claimant undergo a functional capacity evaluation. At that time, Dr. Fleming felt that he had reached maximum medical improvement for his back surgery. He also opined that the Claimant would not be able to return to shipbuilding activities. (EX-9, p. 73-4). Based on this evaluation and continuing pain, the Claimant was instructed that he probably could not return to any gainful employment now or in the future. (EX-9, p. 77). From this point forward Dr. Farris treated the Claimant supportively through the use of medications and physical therapy. (EX-9, p. 78 *et seq.*). He also recommended an additional

operative repair of the Claimant's spinal fusion at L5-S1. (EX-9, p. 93). This surgery was not performed. Dr. Fleming ultimately recommended that the Claimant see another physician regarding this problem when Dr. Fleming retired. (EX-9, p. 101).

In late 1999, Claimant was authorized by Employer to see a psychiatrist for various problems that he alleged were related to his workplace accident. Employer authorized this treatment, and Claimant went to see his chosen physician, Dr. MacGregor on September 22, 1999. During this visit, MacGregor determined that the Claimant was suffering from Dysthymic Disorder. MacGregor explained that the symptoms of this disorder included, among others, depressive moods, pent up anger and irritability, verbal temper outbursts, strained interpersonal relationships, and fleeting homicidal ideation. (EX-7, p. 3).

Doctor MacGregor indicated that the Claimant's symptoms had begun shortly after his industrial accident. In Dr. MacGregor's opinion, the Claimant's condition was a direct result of his accident during which he injured his knee.[8] (EX-7, p. 3). Doctor MacGregor felt that the Claimant was a good candidate for psychiatric treatment and asked for further authorization from Avondale. He felt that without additional treatment, Claimant's condition might worsen. (EX-7, p. 4).

Claimant was also examined by Dr. Bianchini at the request of his Employer. Doctor Bianchini reported that the Claimant's problems are apparently related more to his age and his anger with Avondale than they are to his physical injury. (EX-16, p. 3). Considering Dr. Mabey's observations of the Claimant's severe job dissatisfaction, the Court agrees with this assessment. He also indicated that Claimant told him that his outward symptoms had not developed until 10 years after his original accident, and perhaps after he started treating with Dr. MacGregor. (EX-16, p. 3). Although he felt that there was no clear evidence that the psychiatric treatment was helping the Claimant, Dr. Bianchini recommended that the frequency of his treatments be increased. (EX-16, p. 3).

On one occasion, Dr. Koy had seen the Claimant in place of Dr. MacGregor. Doctor Koy saw the Claimant following one of his rage attacks in which he threatened his girlfriend. Koy did not offer any

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[8]Dr. MacGregor includes the Claimant's other injuries in this same accident, however, as the evidence reflects, this is inaccurate.

possible causes for the Claimant's condition, but indicated that he should receive more frequent psychiatric treatments. (EX-10).

The Claimant also had an independent psychiatric evaluation performed by Dr. R.W. Culver. Doctor Culver took a complete history of the Claimant. He discovered through taking this history that the Claimant had several different problems. He diagnosed the Claimant as having a possible adjustment disorder, borderline intellectual functioning, and a personality disorder with prominent antisocial features. (EX-18, p. 11-2). Culver also ascertained that the Claimant had a history of illegal activity including a conviction for auto theft as a teenager, and a history of income tax evasion. Culver notes that this history does not appear in the medical notes of the other psychiatrists who have seen the Claimant. (EX-18, p. 14). Culver explains that the Claimant had exaggerated his weight loss and other symptoms during the course of his physical treatment and that he failed to cooperate in rehabilitation efforts. (EX-18, p. 14). This caused Dr. Culver to question whether or not the Claimant was being truthful about his other symptoms and psychiatric problems might be exaggerated. Dr. Culver felt that the Claimant might be malingering. (EX-18, p. 15). He recommended against further psychiatric treatment and in favor of attempting to return the Claimant to work of which he was physically capable.

DISCUSSION

I. Jurisdiction

The Parties have not contested jurisdiction in this case. The Claimant was injured while working as a shipfitter at Avondale Shipyard's facility on the navigable waters of the Mississippi River in Louisiana. Thus, Claimant was an employee within the meaning of Section 902 (3) of the Act. He was also employed in a maritime location with respect to Section 903(a) of the Act. *See* 33 U.S.C. § 902, 903(a).

II. Evidence

On January 11, 2001, this court ordered the Employer to produce evidence of the Claimant's weekly wage records between May 12, 1989 and September 28, 1990. Pursuant to that order, Employer's Counsel moved the Court to allow the introduction of said evidence on January 26, 2001 and attached Exhibit A, the wage records we requested. The Court hereby grants Employer's motion and accepts Exhibit A which we will insert in the Record as Employer's Exhibit 40.

III. Claimant's Prima Facie Case

In order to receive compensation under the Act, the Claimant must make out a prima facie case that he was injured within the course and scope of his employment and that this injury has resulted in a disability. In order to make out the prima facie case, the Claimant must demonstrate that he suffered some harm or pain. *See Murphy v. SCA/Shayne Brothers*, 7 BRBS 309 (1977), *aff'd mem.*, 600 F.2d 280 (D.C. Cir 1979). The Claimant must also demonstrate that an accident occurred or working conditions

existed which could have caused the pain or harm. *See Kelaita v. Triple A. Mach. Shop*, 13 BRBS 386 (1981).

Here we have a gentleman who was clearly injured. He sought treatment for two specific injuries from Dr. Mabey, the physician at Avondale Shipyard. (CX-22, p. 6; TX, 32; CX-22, p. 29). Further there is evidence that both of these injuries could have resulted from a workplace accident or condition. (CX-22, p. 6; TX, 32; CX-22, p. 29).

Claimant's first injury occurred on May 22, 1990 when he hurt his back. (CX-22, 7). His treating physician for this injury was Dr. Mabey, Avondale's yard doctor. (CX-22, p.8). Doctor Mabey opined based on his examination of the Claimant and the Claimant's statements to the doctor that Claimant reached maximum medical improvement for this injury on September 18, 1990. (CX-22, p. 27). Claimant did not report this injury to or receive treatment from another physician. The Court accepts Dr. Mabey's opinion that the Claimant had reached Maximum medical improvement from this injury and was able to return to work as of September 18, 1990. The record reflects that Claimant actually did return to work for some period before this date, with only a minimal period restricted to light duty. (CX-22, p. 16, *et seq.*).

Claimant's second injury occurred on September 25, 1990. (CX-22, p.29). He reported to Dr. Mabey for treatment following this injury to his knee on October 16, 1990. (CX-22, p. 29). During the treatment of this injury Claimant did not mention any back, neck, or shoulder pain to any of the treating physicians. (CX-22, p. 36; EX-9, p. 10, 11). He was treated by Drs. Russo and Fleming for the injury to his knee. This treatment included surgery for the Claimant's knee injury and referrals to physical therapy. (EX-9, p. 4-8). Claimant's treating physicians, Drs. Farris and Russo, put him at maximum medical improvement for his knee injury on July 19, 1991. (EX-9, p.21). Doctor Farris also stated at that point that he could not offer any opinion with respect to the Claimant's back complaints because the Claimant had never voiced these to him. (EX-9, p. 21).

In May of 1992, almost two years after his initial back injury and substantially after reaching maximum medical improvement for both of his workplace injuries, Claimant saw Dr. Farris and complained of back and neck pain. Farris felt that the Claimant might have a slight sprain to his back and referred him to physical therapy. (EX-9, p. 22). The Claimant failed to comply with his doctor's instructions, however, and was released from physical therapy and from Dr. Farris' care in July of 1992. (EX-9, p. 24). Claimant subsequently saw Dr. Farris with further complaints of back and neck pain and was treated for the same beginning in September of 1992. (EX-9, p. 25).

Subsequent treatment of Claimant's injuries was accomplished by Dr. Klainer. (EX-9, p. 25, *et seq.*). Dr. Klainer mentions in his notes that the Claimant's back injuries are apparently related to his workplace injury of May 12, 1989. (EX-9, p. 15-6). This is obviously inconsistent with the Claimant's statement and the parties stipulation that his injury occurred on May 25, 1990. (JX-1; TX, p. 32). We

have considered the whole of the medical and employment records in this case, and we find no record of an injury involving Claimant's back on May 12, 1989. The Court therefore finds that the Claimant has not made out a prima facie case that the pain he reported to Dr. Farris and received treatment for could have been caused by a work related accident or condition of that date.

In the alternative, the Court has considered the possibility that Dr. Klainer's records contain a typographical error. Even if this is the case, considering the whole of the evidence presented, the Court does not find sufficient evidence that this back pain was caused by the Claimant's work place accident in 1990. Indeed, Dr. Mabey, who treated the Claimant for that injury, indicates in his medical records that the Claimant's back problems are the result of normal degenerative changes. (CX-22, p. 12). The Court considers Dr. Mabey's opinion to be a medical diagnosis of the best quality. We have no reason to doubt his diagnosis or his treatment decisions with respect to this Claimant. Considering all of the medical evidence presented, the Court finds that even if Dr. Klainer's medical report contains an error, that error is not sufficient, weighed against Dr. Mabey's opinion, to demonstrate that the Claimant's back problems are related to a work place injury or condition.

Simply put, the Court finds that the Claimant hurt his back on May 22, 1990. He reached maximum medical improvement on September 18, 1990, and was returned to work. He did not complain significantly about his back pain again until May 1992. We find that there are two separate back injuries in this case. One was caused by the Claimant's workplace accident, the other was not.

The Court finds that this progression, combined with the Claimant's two year extended absence from work, indicates that his condition was not caused by a workplace injury. Accordingly, the Court treats this as a separate injury. Claimant makes no specific allegation that the back injury for which he was treated beginning in May 1992 was caused by a workplace condition or accident. The Supreme Court has held that the claim for compensation must arise out of and in the course and scope of employment. Mere existence of physical impairment is not enough. *See U.S. Industries/Federal Sheet Metal v. Director, OWCP (Riley)*, 455 U.S. 608, 14 BRBS 631, 633 (1982). The Court finds that this injury is too far removed from the 1990 accident to be connected without more. We would require either a specific showing of an additional workplace accident or additional evidence from a treating physician to make this connection. As that evidence is absent, the Court finds that the Claimant has not met his burden to prove that his spinal injuries are work related.

Although Claimant testified to the relationship of this injury to his workplace accident at trial, the Court is disinclined to believe his testimony. The Claimant damaged his credibility when he testified that Dr. Mabey put him out of work for several days as a result of his back injury. In reality, Dr. Mabey's testimony and records indicate that the Claimant was put out of work because of severe job dissatisfaction. (*Compare* TX, 32 *with* CX-22, 13-4). Claimant also testified that he completed the work hardening program at West Jefferson Hospital. (TX, 42-3). Doctor Farris' medical records, however, show that Claimant did not complete the program because he did not participate fully. He was released from the program and Dr. Farris care for this reason. (EX-9, p. 19-21). Moreover, Claimant testified that he has

difficulty performing day to day activities and going to work. (TX, 85-6). The surveillance videos, however, indicate that the Claimant is more than capable of carrying out these basic functions. One video shows him fishing and barbecueing. In this video he bends, sits, stands, walks, and uses vigorous arm motions for extended periods. (EX-37). The inconsistencies in the Claimant's testimony lead the Court to conclude that his representation of events is unreliable. We therefore turn to the evidence offered by other parties in making our decision.

Section 20(a)

With respect to the original back, neck, shoulder, and knee injuries that occurred in 1990, the Court finds that the Claimant has made out his prima facie case. The Claimant is therefore entitled to the presumption under Section 20(a) of the Act that these injuries come within the provisions of the Act. *33 U.S.C. § 920(a)*. Once the Claimant has met his burden and the presumption is invoked, it is Employer's burden to go forward with substantial evidence that the injury did not arise out of the Claimant's employment. *See Swinton v. J. Frank Kelly, Inc.*, 554 F.2d 1075, 1082, 4 BRBS 466, 475, (D.C. Cir.), *cert. denied*, 429 U.S. 820 (1976).

In this case, the Employer presents no evidence rebutting the presumption with regard to the Claimant's back, neck, and shoulder strain in May of 1990. Employer also presents no evidence rebutting the presumption with respect to the Claimant's September 1990 knee injury. The Court therefore finds that both of these injuries are work related and compensable under the act. With respect to these injuries only, we make the following findings.

III. Nature and Extent of Claimant's Disability

Temporary Total Disability

As pertains to the Claimant's compensable back injury, the parties stipulate that the Claimant was temporarily totally disabled from June 9, 1990 until June 13, 1990. (JX-1). Benefits were paid for this period at a rate of $192.69 per week. (JX-1). The Claimant and Employer have also stipulated that Employer has paid benefits for temporary total disability from this injury during the period October 1, 1992 until September 29, 1999 at the same rate. (JX-1). The Court accepts the stipulation for the first period of temporary total disability. Because we find that the Claimant's 1992 back problem was not work related, however, we cannot accept the stipulation to temporary total disability from October 1, 1992. The Employer is entitled to credit for the amount paid during this period.

The parties stipulate that the Claimant was temporarily totally disabled by his knee injury from November 5, 1990 until July 28, 1991. (JX-1). Employer paid temporary total disability benefits during this period at a rate of $206.72 per week. Employer also paid temporary total disability for this injury from June 5, 1992 until June 22, 1992 at the same rate. (JX-1). The Court accepts these stipulations and finds that the Claimant was so disabled and entitled to compensation.

Finally, Employer paid Claimant 5% permanent partial disability for 14.4 weeks at the same rate for his knee injury. (JX-1). The Court finds, and the parties agree that the Claimant has suffered a 5% permanent partial loss of use of his leg. Accordingly, he is entitled to compensation for the scheduled loss of the leg running for the proportionate number of weeks attributable to the loss of the limb. *See Nash v. Strachan Shipping Co.*, 15 BRBS 386, 391 (1983). Under the Act a Claimant

is entitled to compensation for 280 weeks for the loss of use of a leg. 33 U.S.C. § 908(c)(2). The Court accepts the stipulation that compensation for 14.4 weeks at the rate of $206.72 per week is the appropriate compensation for this disability.

Throughout this case, Employer has covered Claimant's medical expenses for treatment related to his workplace injuries. The total amount of these payments is stipulated at $123,807.90 for both injuries. (JX-1). The Court finds that the Claimant was entitled to all medical treatment paid for by the Employer with respect to his knee injury. We therefore accept the stipulation that the Employer has paid $24,684.99 in total medical benefits for this case. Although Claimant does not apparently need further medical assistance for his knee injury at this time, Employer is liable for future reasonable and necessary medical treatment as far as it relates to this injury. The Court further finds that the Claimant is entitled only to compensation for medical costs up to the point of maximum medical improvement for his original back, neck, and shoulder injury, which we find to be September 18, 1990. Employer is entitled to a credit for medical benefits paid in excess of those costs. As the medical benefits are not separated in this way, however, we cannot determine the specific amount of this credit.

Permanent Total Disability

A temporary disability may become permanent under the Act where the Claimant demonstrates either 1) that he suffers from residual disability after the point of maximum medical improvement; or, 2) that his condition has continued for a lengthy period and apparently is of lasting or indefinite duration. *See James v. Pate Stevedoring Co.*, 22 BRBS 271, 274 (1989); *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649, 654 (5th Cir. 1968), *cert. denied*, 394 U.S. 976 (1969).

Claimant's compensable back, neck and shoulder injury reached maximum medical improvement as of September 18, 1990. (CX-22, p. 27). He was returned to work that day without restrictions. (CX-22, p. 16 *et seq.*). There is no evidence of residual disability related to the Claimant's May 22, 1990 neck, back, and shoulder injury. We have previously found that the Claimant has not proved that his continuing

neck problems are related to this workplace accident. We therefore treat this as a second, distinct injury that is not compensable. With respect to the Claimant's September 18, 1990 injury we find that there is no evidence of residual disability. There is also no evidence that the condition is so prolonged as to apparently be of lasting or indefinite duration. Accordingly, it is the Court's considered judgment that the Claimant did not suffer a permanent partial or total disability to his back, neck, or shoulder.[9]

The knee injury Claimant suffered while at work reached maximum medical improvement as of July 19, 1991. (JX-1; EX-9, p.21). As we discussed above, the parties have stipulated that the Claimant is permanently partially disabled by his knee injury. They have also stipulated that the Employer has paid Claimant compensation in an amount which we accept is appropriate for this injury. The Court finds that he is permanently partially disabled as a result of his knee injury and has been compensated appropriately.

Even if the Claimant were able to demonstrate permanent physical disability, it would then be the employer's burden to demonstrate that despite this impairment there are realistically available job opportunities near the Claimant's residence that he is capable of performing considering all of the circumstances. *See Lucus v. Louisiana Ins. Guaranty Ass'n*, 28 BRBS 1 (1994). Employer has presented evidence that the Claimant was able to return to work following both of his injuries. Dr. Mabey originally sent the Claimant back to work at his request after his May 1990 injury. (CX-22, p. 27). During the course of his treatment for this injury, Claimant returned to work and did not complain about any inability to work at his regular position. (CX-22, p. 10-20). Claimant was also not restricted in his duty except for one brief period when he suffered from severe job dissatisfaction. (CX-22, p. 13-15). Following his date of maximum medical improvement from his knee surgery there is evidence that the Claimant could return to light duty work. Employer's surveillance videos show the Claimant driving his car, fishing, bending, stooping, squatting, opening and closing car doors, cooking, and performing other tasks. (EX-37). Claimant's physician indicated that when he reached maximum medical improvement from this injury he was able to return to work. (EX-9, p.21). He also stated that he had had trouble getting the Claimant to participate in therapy, which was necessary for full recovery. (EX-9, p. 21).

Claimant was also returned, briefly, to the services of Avondale's RWRP program. Clay Gelpi, the director of this program, testified at the hearing that jobs had been continuously available at this program since summer of 1999. (TX, 243). Gelpi testified that these jobs were available to the Claimant and that his needs could be accommodated. (TX, 245). Employer also presented the Court with a video describing the tasks and facilities of the RWRP. (EX-36). After watching this video and the surveillance videos of

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[9]Doctor Williams, who saw the Claimant for an independent medical examination did opine that the Claimant has suffered a 25% permanent partial impairment of his body as a whole. This finding was based on the Claimant's back condition, and was determined after his surgery. Therefore, it is not related to one of his compensable injuries and not considered here. (EX-5, p. 4).

the Claimant, the Court is convinced that Claimant is capable of working at least at several of the RWRP positions.

Claimant worked in the RWRP program briefly in 2000. According to the program director, however, his attendance was poor. Mr. Gelpi testified that the Claimant did not complain about the work that he was assigned to do or any of the other conditions at the RWRP. (TX, 243). The Court therefore finds that the RWRP is suitable alternative employment for the Claimant.

Employer also arranged for the Claimant to speak with its supervisor of security guards, Andrew Bradford. He explained a security position to Claimant. This position was "a pedestrian post, walking through and that time I explained you could either sit, stand, or just walk around the immediate area and control the personnel in and out of the gates there." (TX, 263-4). The gatehouse was air conditioned, and a telephone, watercooler, and bathroom were nearby. (TX, 264-5). Despite these conditions, Claimant insisted that his condition would not let him perform the job. (TX, 266). Bradford testified at trial that if Claimant was willing to try this position, it was open and available to him at that point. He also testified that there were four positions currently available. (TX, 266).

Based on this testimony, the medical evidence presented, and the surveillance videos, the Court finds that Claimant could also have performed this position. The Court therefore concludes that suitable alternate employment is available to the Claimant. Accordingly we find that he is not permanently totally disabled by his workplace injuries.

IV. Psychological Disabilities

At the recommendation of his treating physician, Claimant sought and received psychiatric treatment. He was treated primarily by Dr. MacGregor, although he also saw Dr. Koy for an emergency session. (EX-7, p. 4; EX-10). Independent psychiatric examinations were performed by Dr. Bianchini and Dr. Culver. (EX-16; EX-18). The Court has read the opinions of each of these doctors carefully. Doctor MacGregor, the Claimant's treating psychiatrist for our purposes, asserts that Claimant's mental difficulties are related to his workplace accident in September of 1990. (EX-7, p. 3). The Court accepts that this is enough evidence to make the Claimant's prima facie case with respect to his psychiatric harm. *See § 1, infra*. The Claimant is entitled to the Section 20(a) presumption under the Act. The Employer must go forward with evidence that the Claimant's disability was not caused by a workplace accident.

The Court finds that the Employer has also met its burden. Employer's independent examiners took great care to determine Claimant's history and the nature of his problems. Doctor Bianchini asserts that the Claimant's difficulties are not related to his physical injury. (EX-16, p. 3). Doctor Culver made no specific finding on this question, but did determine that the Claimant was antisocial and untrustworthy. (EX-18, p. 11, 15). Culver's report indicates that the Claimant is likely malingering and exaggerating his symptoms. (EX-18, p. 15). Based on inconsistencies in his testimony discussed above, the Court agrees with Dr. Culver's assessment regarding the Claimant's reliability. The Court finds that there is sufficient evidence to rebut the presumption and require us to consider the whole of the psychiatric evidence.

After carefully weighing all of the evidence regarding Claimant's psychiatric condition, the Court finds that the Claimant's condition was not caused by a workplace condition or injury. Employer has presented evidence that the Claimant's mental problems are unrelated to his physical injury. The Court accepts Dr. Bianchini's determination that the Claimant's disability is not work related. Doctor Bianchini reports that the Claimant admitted that his psychiatric symptoms did not develop until 10 years after his accident. (EX-16, p.3). The Court therefore finds that the Claimant's mental injury could not possibly be related to his physical injury in the workplace.

In addition to this finding, the Court has considered the possibility that the Claimant's psychiatric problems could be latent results of his workplace injury. We find that the Claimant's problems may be of this nature. As such, they represent the result of his dissatisfaction with Employer's response to his claim. His antisocial tendencies resulted in failed rehabilitation efforts that prevented him from returning to work. Each time medical doctors felt the Claimant had reached maximum medical improvement and was ready to return to the workplace, Claimant developed a new physical complaint. The early stages of this cycle were identified by Dr. Mabey during the course of Claimant's 1990 treatment. There is no evidence that work conditions existed or an accident occurred that caused the psychiatric component of Claimant's condition. The Court thus finds that the Claimant is not entitled to compensation under the Act because the Employer has rebutted the section 20(a) presumption. We find that Claimant' s psychiatric problems are not work related. Employer is not responsible for medical treatment of these problems, and Claimant is not disabled as a result of them.

V. Average Weekly Wage

Claimant and Employer finally lock horns over the thorny question of average weekly wage. Employer contends that the Claimant's average weekly wage was $289.09 based on the Claimant's hourly wage and the number of hours he worked for the company. Claimant responds that the Average Weekly Wage should be $374.40. Claimant urges that the Court should consider the Claimant's average hourly wage vis a vis a 40 hour work week to determine the average weekly wage.

We have previously accepted Employer's offer of evidence on this subject. The additional evidence presented by the Employer is his weekly wage information for the 51 weeks prior to his accident. The Court finds that these records are the best measure of the Claimant's wage earning capacity prior to his injury.

The reality of the Claimant's employment is that he worked outside. As such, his work schedule was subject to weather conditions. New Orleans, of course, is prone to heavy rains. Given this, the wage evidence presented by Employer indicates that Claimant seldom worked a full 40 hour week. (EX-40). The Claimant's irregular hours and missed weeks of work force the Court to make a determination based on the information available.

The Court has added the Claimant's net weekly earnings for the 51 weeks prior to his injury as

shown in Employer's records. (EX-40). We find that during this period the Claimant earned a total of $15,343.53. This amount, divided by 51 weeks, results in a figure of $300.85. We therefore find that the Claimant's Average Weekly Wage prior to his injury was $300.85 in accordance with our calculations from the available evidence. We find that this is the appropriate figure under Section 10(a) of the Act. *See 33 U.S.C. § 910(a).*

ORDER

1. Claimant was entitled to compensation for temporary total disability from June 9, 1990 until June 13, 1990 at the rate of $200.56 per week for his compensable back injury based on an average weekly wage of $300.85. Employer is entitled to credit for all temporary total disability payments beyond this period;

2. Claimant was entitled to all temporary total disability paid with respect to his knee injury at the stipulated rate of $200.56 per week and to the stipulated 5% permanent partial disability payments made with respect to this injury;

3. Claimant is entitled to medical treatment for his knee injury in the amount of $23,684.99 as well as future reasonable and necessary medical expenses. Claimant was also entitled to medical expenses for treatment by Dr. Mabey related to his compensable back injury. Employer is entitled to credit for all other medical expenses paid to or on behalf of the Claimant;

4. All other claims for compensation are hereby DENIED;

5. Claimant's Counsel, Arthur Brewster, shall have 20 days from receipt of this order in which to file an attorney fee petition and simultaneously serve a copy of the petition on opposing counsel. Thereafter, Employer shall have 20 days from receipt of the fee petition to respond to said petition.

So ORDERED.

RICHARD D. MILLS
Administrative Law Judge

RDM/ct